UMC HEALTH SYSTEM
UNIVERSITY MEDICAL CENTER
Lubbock, Texas

Patient Label Here

DISCLOSURE AND CONSENT MEDICAL AND SURGICAL PROCEDURES

TO THE PATIENT: You have the right as a patient to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I (we) voluntarily request Doctor(s)_____as my physician(s), and such associates, technical assistants and other health care providers as they may deem necessary, to treat my **condition** which has been explained to me (us) as (**lay terms):** Ruptured Disk

2. I (we) understand that the following surgical, medical, and/or diagnostic **procedures** are planned for me and I (we) voluntarily consent and authorize these **procedure**s (**lay terms):** Anterior Cervical Discectomy and Fusion - a small incision is made in the front of the neck to remove the ruptured disc to relieve pressure on the spinal cord. Then a bone graft will be used to fill the disc space and fuse the vertebrae together

3. **INTRAOPERATIVE NEUROPHYSIOLOGICAL MONITORING:** I (we) understand that intraoperative neurophysiological monitoring (IOM) may be utilized to identify neural structures, aid in performing the surgical procedure, and detect and prevent injury to the nervous system.

Please check appropriate box: ☐ Right ☐ Left ☐ Bilateral ☐ Not Applicable

4. I (we) understand that my physician may discover other different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

5. Please initial _____**Yes** _____ **No**

I consent to the use of blood and blood products as deemed necessary. I (we) understand that the following risks and hazards may occur in connection with the use of blood and blood products:

a. Serious infection including but not limited to Hepatitis and HIV which can lead to organ damage and permanent impairment.
b. Transfusion related injury resulting in impairment of lungs, heart, liver, kidneys and immune system.
c. Severe allergic reaction, potentially fatal.

6. I (we) understand that no warranty or guarantee has been made to me as to the result or cure.

7. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following hazards may occur in connection with this particular procedure: Pain, severe bleeding, infection, weakness, numbness or clumsiness, impaired muscle function or paralysis, incontinence, impotence, or impaired bowel function (loss of bowel/bladder control and/or sexual function), migration of implants (movement of implanted devices), failure of implants (breaking of implanted devices), adjacent level degeneration (breakdown of spine above and/or below the level treated), cerebrospinal fluid leak with potential for severe headaches, meningitis (infection of coverings of brain and spinal cord), recurrence, continuation or worsening of the condition that required this operation (no improvement or symptoms made worse), unstable spine (abnormal movement between bones and/or soft tissues of the spine)

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Anterior Cervical Discectomy (cont.)

8. I (we) understand that Do Not Resuscitate (DNR), Allow Natural Death (AND) and all resuscitative restrictions are suspended during the perioperative period and until the post anesthesia recovery period is complete. All resuscitative measures will be determined by the anesthesiologist until the patient is officially discharged from the post anesthesia stage of care.

9. I (we) authorize University Medical Center to preserve for educational and/or research purposes, or for use in grafts in living persons, or to otherwise dispose of any tissue, parts or organs removed except: NONE _____.

10. I (we) consent to the taking of still photographs, motion pictures, videotapes, or closed circuit television during this procedure.

11. I (we) give permission for a corporate medical representative to be present during my procedure on a consultative basis.

12. I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, potential benefits, risks, or side effects, including potential problems related to recuperation and the likelihood of achieving care, treatment, and service goals. I (we) believe that I (we) have sufficient information to give this informed consent.

13. I (we) certify this form has been fully explained to me and that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

IF I (WE) DO NOT CONSENT TO ANY OF THE ABOVE PROVISIONS, THAT PROVISION HAS BEEN CORRECTED.

I have explained the procedure/treatment, including anticipated benefits, significant risks and alternative therapies to the patient or the patient's authorized representative.

Date	Time	Printed name of provider/agent	Signature of provider/agent
_____	_____ A.M. (P.M.)	_____	_____

Date	Time
_____	_____ A.M. (P.M.)

_____
*****Patient/Other legally responsible person signature — Relationship (if other than patient)

_____
*Witness Signature — Printed Name

☐ UMC 602 Indiana Avenue, Lubbock, TX 79415 ☐ TTUHSC 3601 4th Street, Lubbock, TX 79430
☐ UMC Health & Wellness Hospital 11011 Slide Road, Lubbock TX 79424
☐ OTHER Address: _____
Address (Street or P.O. Box) — City, State, Zip Code

Interpretation/ODI (On Demand Interpreting) ☐ Yes ☐ No _____
Date/Time (if used)

Alternative forms of communication used ☐ Yes ☐ No _____
Printed name of interpreter — Date/Time

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Date _____

Resident and Nurse Consent/Orders Checklist

Instructions for form completion

Note: Enter "not applicable" or "none" in spaces as appropriate. Consent may not contain blanks.

Section 1: Enter name of physician(s) responsible for procedure and patient's condition in lay terminology. Specific location of procedure must be indicated (e.g. right hand, left inguinal hernia) & **may not be abbreviated.**

Section 2: Enter name of procedure(s) to be done. Use lay terminology.

Section 3: The scope and complexity of conditions discovered in the operating room requiring additional surgical procedures should be specific to diagnosis.

Section 5: Enter risks as discussed with patient.

A. Risks for procedures on List A must be included. Other risks may be added by the Physician.
B. Procedures on List B or not addressed by the Texas Medical Disclosure panel do not require that specific risks be discussed with the patient. For these procedures, risks may be enumerated or the phrase: "As discussed with patient" entered.

Section 8: Enter any exceptions to disposal of tissue or state "none".

Section 9: An additional permit with patient's consent for release is required when a patient may be identified in photographs or on video.

Provider Attestation: Enter date, time, printed name and signature of provider/agent.

Patient Signature: Enter date and time patient or responsible person signed consent.

Witness Signature: Enter signature, printed name and address of competent adult who witnessed the patient or authorized person's signature

Performed Date: Enter date procedure is being performed. In the event the procedure is NOT performed on the date indicated, staff must cross out, correct the date and initial.

If the patient does **not** consent to a specific provision of the consent, the consent should be rewritten to reflect the procedure that the patient (authorized person) is consenting to have performed.

For additional information on informed consent policies, refer to policy SPP PC-17.

Consent

☐ Name of the procedure (lay term)	☐ Right or left indicated when applicable
☐ No blanks left on consent	☐ No medical abbreviations

Orders

☐ Procedure Date	☐ Procedure
☐ Diagnosis	☐ Signed by Physician & Name stamped

Nurse_____ Resident_____ Department _____

THIS FORM IS NOT PART OF THE MEDICAL RECORD